MEDICOLEGAL GRAND ROUNDS

PATIENT NEGLIGENCE

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The general concept that individuals have a legal obligation to refrain from negligent acts that cause injury to others is well recognized. Whether operating a vehicle or using dangerous machinery, we are legally bound to exercise caution and not negligently injure others. A companion duty requires people to refrain from negligently exposing themselves to harm. This responsibility is the basis for the common law doctrine of contributory negligence.[1] When a person who complains of having been negligently injured by another has, in fact, unreasonably exposed himself to that injury, the issue of contributory negligence arises.

CONTRIBUTORY NEGLIGENCE

The legal effect of contributory negligence, once proven, is that it can bar the plaintiff's recovery for the injuries sustained.[2] In certain jurisdictions, by alleging and proving that the plaintiff's negligence contributed to the injury, a defendant will be relieved of liability.* Those courts bar any recovery, despite proven negligent conduct by a defendant, when there is the slightest contributory negligence by a plaintiff.

Contributory negligence occasionally arises in the context of medical malpractice. For example, when a patient alleges that a physician's negligent diagnosis or treatment has resulted in injury, the physician can seek to avoid liability by interposing the defense of contributory negligence. A patient's failure to provide an accurate medical history or the provision of a false history that prevents accurate diagnosis and proper treatment can bar a patient's recovery. The following cases are illustrative.

A patient in Indiana had been seen by his family physician over a period of years for multiple recurrent complaints, including chest pain.[3] He had been variously diagnosed by this and other physicians as suffering from "stress reaction" and "tension state." In conjunction with an insurance physical examination, the patient underwent a treadmill stress test that indicated possible coronary artery disease. His family physician received this test result and asked the patient whether he had experienced any recent chest pain. The patient denied recent pain.

The family physician ordered a blood lipid profile and instructed the patient to stop smoking and to return for further evaluation. The patient was also instructed to immediately report to a hospital in the event of any chest pain.

The patient failed to undergo blood lipids testing or return to his physician for further evaluation. The following month, he experienced chest pain prior to work. Contrary to instructions, he failed to seek medical attention. Although the pain initially abated, it returned during work, and a fatal heart attack ensued.

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*Contributory negligence, acting as a complete bar to recovery, remains the law in Alabama, the District of Columbia, Maryland, North Carolina and Virginia.

The family physician was sued by the decedent's wife. She alleged that the physician had been professionally negligent when he failed to seek immediate cardiology consultation upon learning of the stress test result. The defendant physician interposed the defense of contributory negligence. He pointed to the decedent's failure to provide an accurate medical history regarding his chest pain and failure to follow instructions for diagnostic tests and further medical evaluation. The decedent's wife admitted that, prior to the evaluation when the decedent denied chest pain, he had frequently experienced pain so severe that he thought he would die.

Affirming a judgment for the defendant physician, the appellate court agreed that contributory negligence can apply to medical malpractice actions. A duty to behave as other reasonable persons would under similar circumstances was determined to apply not only to physicians but also to patients. The court observed that if a patient acts unreasonably by relating a false medical history or not following doctor's instructions, the patient cannot hold the physician liable for the consequences of his own unreasonable conduct. It was recognized that the patient does not have a duty to diagnose his condition. He does, however, have a duty to provide accurate information and to complete relevant diagnostic tests. If death or injury results from failure to follow doctor's instructions, the physician may not be held liable.

The Supreme Court of Delaware reached a similar result in another case.[4] There, an individual who had been taken into custody by police was brought to a hospital for treatment of an injury. Shortly before his arrest, the patient had consumed beer and several Librium capsules. He falsely told emergency room personnel that he was a heroin addict who used "four or five bags of heroin daily." He appeared agitated and complained of abdominal pain and other withdrawal symptoms. The emergency physician specifically queried the patient about his participation in a methadone program. The patient responded that he had taken methadone for four months but stopped when he found a new heroin source. He claimed to be an addict suffering withdrawal, and he requested medication.

Responding to this fabricated history, the physician ordered 40 milligrams of methadone. A second 40 milligram dose was administered when the patient claimed he needed more medication. Once calmed down, the patient was removed from the hospital by police and incarcerated. The next morning, he was found unresponsive and was returned by ambulance to the same hospital, where he was pronounced dead. An autopsy, including toxicological tests, disclosed that he had died from mixed drug intoxication.

The patient's estate filed a lawsuit. The court concluded that even if negligent treatment by the physician were assumed, the patient's own conduct significantly contributed to his death and barred recovery. While the physician may have been negligent in accepting the veracity of the patient's addiction history, the patient also was negligent in relating a false medical history, failing to divulge recent Librium and alcohol ingestion, and requesting a potentially fatal dose of methadone. Under those circumstances, contributory negligence was a causal factor in the patient's death, and his deception prevented any recovery.

A final illustration is provided by a 1982 case from Georgia.[5] In this instance, the question was whether the failure to disclose a history of allergies could constitute contributory negligence. A

family physician referred a woman with persistent wrist pain to an orthopedic surgeon. The orthopedist testified that, after he had specifically inquired, the patient denied a history of any allergies. Butazolidin was prescribed, and the woman subsequently developed Stevens-Johnson syndrome. When later hospitalized for this condition, she related "a long history of allergies to numerous medications and contact substances."

The patient's contributory negligence was successfully raised as a defense. The patient appealed, arguing that non-disclosure of medical history could never constitute contributory negligence. The court disagreed and the trial court verdict was affirmed. Patients were found to have a duty to exercise reasonable care. In this case, that duty included disclosure of relevant allergies. Under certain circumstances, a patient's failure to relate an accurate medical history can constitute contributory negligence.

Without the proper factual situation, contributory negligence may fail as a defense. In a Missouri case, a patient's mother consulted her child's physician by telephone several times over the course of a week.[6] The child was experiencing abdominal pain with vomiting and diarrhea. Pain medication was advised. When finally examined, the child was diagnosed with an acute abdomen, and a ruptured appendix was discovered at surgery.

Appealing a lower court's determination that the child's diagnosis was negligently delayed, the defendant physician argued that the delay occurred because the patient's mother had provided him with an incomplete and confusing medical history. The appellate court disagreed and concluded that the mother had provided the physician with a sufficient history. There was no contributory negligence, and the earlier decision was affirmed.

In a New York case, a woman whose addiction to Nembutal was clearly documented in the records of one hospital was subsequently admitted to another.[7] Although the patient reported that she had been taking Nembutal, she was not asked if she abused drugs. During this admission, the patient suffered a convulsive seizure and died.

Contributory negligence in failing to disclose a drug addiction was raised as a defense at a subsequent medical malpractice trial. The court reasoned, however, that a patient's failure to volunteer a history of drug addiction does not equate with contributory negligence. In this case, the physician neither interviewed the husband nor examined the other hospital's records, sources that were determined to have been readily available. As a result, the court found no contributory negligence on the patient's part and awarded damages to her estate.

COMPARATIVE NEGLIGENCE

A complete bar to recovery when a plaintiff's contributory negligence is minimal has been widely regarded as a harsh legal result. Most jurisdictions have consequently adopted the doctrine of comparative negligence. By the end of 1993, only five had not substituted comparative negligence for contributory negligence, by either legislation or judicial decree. Those jurisdictions are Alabama, Maryland, North Carolina, Virginia, and the District of Columbia.[8]

Under comparative negligence, damages are reduced proportionately by any share of negligence on the part of the plaintiff. The majority of comparative negligence states have required that the plaintiff's negligence compared to the defendant's be either "not as great" (less than 50%) or "not greater than" (50% or less). Otherwise, the common law contributory negligence doctrine applies.[9]

In an Oklahoma case, a woman presented to her family physician with a lump in her left breast.[10] A mammogram was performed, and the physician informed the patient that the lump was "not cancerous". Over the next two years, the doctor evaluated the patient for other problems on several occasions. In time, the patient consulted another physician for the breast lump. The second physician observed that the lateral aspect of the left breast was extensively involved in "a malignant process" and requested an immediate surgical consultation. Despite a mastectomy and chemotherapy, the patient died within a year.

Prior to her death, the patient had instituted a malpractice suit against the physician who had evaluated her initially. She contended that she had continued to complain about her breast lump during his subsequent evaluations. At trial, the physician ardently maintained that the lump was never mentioned during the subsequent visits.

The jury ultimately found that the physician was 40 percent negligent and the plaintiff 60 percent negligent. Given the rule for comparative negligence in that jurisdiction, no damages were awarded to the woman's estate. If the assigned proportions of negligence had been reversed, the estate would have received some damages. The award would have been an amount reflecting the total damages reduced by the woman's share of negligence.

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Both contributory and comparative negligence appear in medical malpractice litigation. While there is no legal duty that patients diagnose and treat their own ailments, they do have a duty to avoid conduct that unreasonably exposes themselves to injury.

REFERENCES

1. 65A C.J.S. § 116.
2. 65A C.J.S. § 130.
4. *Fall v. White*, 449 N.E.2d 628 (Ind. App. 1983).
5. *Rochester v. Katalan*, 320 A.2d 704 (Del. 1974).
6. *Haynes v. Hoffman*, 164 Ga. App. 236, 296 S.E.2d 216 (1982).
7. *Tierney v. Berg*, 679 S.W.2d 919 (Mo. App. 1984).
8. *O'Neill v. State*, 66 Misc. 2d 936, 323 N.Y.S.2d 56 (1971).
9. Horsley WF. The argument for comparative fault. North Carolina Bar Quarterly. 1991;31:19.
10. Prosser WL, et al. Torts -- Cases and Materials, 8th ed. Mineola, NY: The Foundation Press, Inc.; 1982.
11. *Estep v. Pope*, 842 P.2d 360 (Okla. Ct. App. 1992).